County Name: _____

HSD-4 ARRANGEMENTS FOR MEDICARE REQUIRED SERVICES

Required Services	Name and Address of Provider *(If Group, IPA, PHO, Direct or Staff, so state)*
Ambulance Services	
Blood Transfusions	
Bone Density Measurement	
Chiropractic Services (limited)	
Colorectal Cancer Screening	
Comprehensive Outpatient Rehabilitation Facility (CORF)	
Dental Services (limited)	
Diabetes Outpatient Self-Management	
Diagnostic Radiology/Mammography	
Drugs and Biologicals	
Durable Medical Equipment	
Emergency Services	
Heart Transplants	
Hepatitis B Vaccine	
Home Health Services	
Immunosuppressive Drugs	
Lung & Heart Transplants	
Lung Transplants	
Liver Transplants	
Mammogram	
Optometry Services (limited)	
Outpatient Hospital Services	
Outpatient Physical and Occupational Therapy; Speech Pathology Services	
Outpatient Treatment of Mental Illness	
Outpatient Surgical Services	
Pancreas Transplants	
Pap Smear and Pelvic Exams	
Pathology Services	
Pneumococcal Vaccine	
Podiatric Services (limited)	
Prostate Cancer Screening	
Prosthetic Devices, including eyeglasses/contact lenses for aphakia	
Renal Dialysis and Kidney Transplantation	
Therapeutic Radiology	

Prepare a separate table for each county requested

DIRECT ARRANGEMENTS FOR MEDICARE REQUIRED SERVICES **TABLE: HSD-4**

Instructions:

Provide a separate table for each county or partial county.

Column Explanations:

1. Required Services - Self-explanatory

2. Name and Address of Providers for Medicare Beneficiaries - Enter provider name and address where services are provided. If provider is Group, IPA, PHO, Direct w/Plan or Staff indicate name of entity; if provided by more than one source, state all sources. If any of these required services are provided through arrangements with subcontractors indicate name of entity.